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# The California Euthanasia Initiative

by

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## Introduction

On November 3, 1992, Californians will have the opportunity to vote on a ballot initiative that would legalize active euthanasia in the state. It is entitled "The California Death with Dignity Act,"<sup>1</sup> and is an updated version of a similar initiative that failed to qualify for the 1990 ballot.<sup>2</sup> Only the most ardent supporters and opponents of the initiative are predicting the outcome of the vote with certainty. Many observers and analysts within the bioethics community are unsure about the prospects of the initiative for passage into law.

In 1991, a similar initiative in the state of Washington was decisively defeated when it seemed certain to be voted into law.<sup>3</sup> Like the California initiative, this one made it to the ballot on its second attempt, having failed in 1988. The story behind what went wrong in Washington is a fascinating one and provides a likely scenario for how the public debate on the initiative will be conducted in California. As one would expect, the media played a dominant role in the public discussion, but campaign strategists were faced early on in the campaign with the difficulty of communicating complex philosophical arguments in thirty second commercial spots on television. As a result, the debate over the issue was full of passion that often obscured the real issues. Experts in bioethics were paraded in front of the cameras with their testimony, and some of the most moving testimonies, particularly those in favor of legalizing euthanasia, were made in hospital rooms, intensive care units and hospices.

In the final analysis, the initiative in Washington was the victim of bad timing. Events that unfolded around election day in 1991 called attention to euthanasia and placed it in a negative light. These included the publication of Derek Humphry's bestselling book, *Final Exit*, the revelation that Humphry's first wife was coerced by him into accepting euthanasia in 1975, and the increasing negative publicity given to Dr. Jack Kervorkian and his "suicide machine." As a result, an initiative that at first seemed certain to pass was defeated.

There is little doubt that technology has increased the ability of medicine to

prolong life in increasingly poor quality of life circumstances. One of the results of this is that patients increasingly fear being held hostage to medical machinery that they do not desire, thereby losing control of one of the most intimate and private aspects of one's life, that is, one's death. It is not only the elderly that express these fears. For example, as more and more people who are infected with the HIV virus develop AIDS and experience the physical breakdown that accompanies the advance of the disease, one should not be surprised at the growing number of non-elderly persons who are requesting assistance in suicide. Thus the ballot initiatives in Washington and California are likely to be reproduced around the country.

This paper will provide an analysis of the California initiative. Special attention will be given to the Dutch experience of loosely legalized euthanasia in order to determine the degree to which it can be used as a model for the practice of euthanasia in the United States.<sup>4</sup>

### **The California Death with Dignity Act — Its Main Features**

The initiative is quite lengthy, consisting of thirteen single spaced pages, so the analysis will proceed from a summary of the most important features of the proposed law. The initiative only gives legal *permission* for physicians to perform euthanasia if their moral and religious principles allow them to do so. If the initiative is passed, no physician will be *required* to assist in providing aid in dying should such a practice violate his or her principles of medical practice.<sup>5</sup> However, the physician in that position would have a responsibility for transferring the patient to another physician who could ethically fulfill the patient's request.<sup>6</sup>

Euthanasia is called "*aid-in-dying*" throughout the initiative. That is a very broad term and for the sake of definition, it refers to "a medical procedure that will terminate the life of the qualified patient in a painless, humane and dignified manner, whether administered by the physician at the patient's choice or direction, or whether the physician provides means to the patient for self-administration."<sup>7</sup> *Active euthanasia* is the term normally used to describe the active intervention of the physician to cause the death of the patient, usually through lethal injection of drugs or introduction of such a drug into a patient's intravenous feeding line. *Physician assisted suicide* is the term for the physician providing the drugs and the direction necessary for the patient to carry out suicide by himself or herself. Technically they are different ways of providing aid in dying, active euthanasia being one that involves the physician more directly. The initiative seeks to legalize both active euthanasia and physician assisted suicide under the broad heading of aid in dying.

This is different from physician supervised withdrawal of life sustaining treatment from a patient who requests it. The right of a competent patient to refuse any treatment, even life sustaining treatments such as a respirator and artificially provided nutrition and hydration, has become more accepted in the medical profession, the courts and in society in general. This right is not in question in this initiative. What is at issue is the right of a patient to enlist the aid

of a physician in order to actively terminate his or her life.

The right to enlist such assistance of a physician applies only to "qualified patients."<sup>8</sup> A qualified patient is adult (it does not apply to children or minors) who is (a) mentally competent to make decisions in his or her best interests, (b) with a terminal illness,<sup>9</sup> who in the certified judgment of two physicians, will not live longer than six months, (c) who has expressed an "enduring request" (which means he or she has requested euthanasia more than once<sup>10</sup>), and (d) in one of those requests there has been written down some kind of revocable advance directive to the physician.<sup>11</sup> This directive must be witnessed (there is a suggested form for the patient to follow in writing the advance directive and the witness to follow in witnessing it<sup>12</sup>), and may be revoked at any time by destroying the directive, substituting another written directive or verbally declaring the intent to revoke it.<sup>13</sup> If the patient is a resident of a skilled nursing facility, the initiative states that one of the witnesses for this directive must be the Patient Advocate or Ombudsman.<sup>14</sup>

Not only is the physician immune from legal liability for practicing euthanasia, but the physician, patient/family, and other health care professionals and facilities are specifically exempted from any insurance problems.<sup>15</sup> For example, a life insurance company could not refuse to pay death benefits to the beneficiaries named by a patient who chose euthanasia.<sup>16</sup> Nor can a health insurance company prohibit or require a euthanasia directive as a condition for the patient's continued insurance.<sup>17</sup> The thrust of this section is that a patient who has a euthanasia directive cannot be treated any differently for insurance purposes than if he or she did not have such a directive. Similarly, no health care provider or service plan (presumably a Health Maintenance Organization, or HMO) would be allowed to deny services on the basis of a patient either having or not having a euthanasia directive.<sup>18</sup> The presence or absence of this kind of euthanasia directive is to have no impact on one's insurance or access to medical care.

The initiative is sensitive to the possibility that a person's consent to euthanasia may not be completely voluntary. That is, he or she may be the object of some kind of undue influence to sign a euthanasia directive. For example, family members may put subtle pressure on the patient because the cost of his or her long term care is financially burdensome. Anyone who uses coercion to force a patient to seek aid in dying is guilty of a misdemeanor, and if the fraudulent directive is carried out and results in the patient's death, the person who used the undue influence is guilty of a felony.<sup>19</sup>

A further safeguard against possible abuses is that hospitals and other health care providers who perform euthanasia are required to report the cases in which euthanasia was administered to the State Department of Health Services.<sup>20</sup> This is to be done annually and in confidence, thereby protecting the identity of the patients involved.

### **The California Death with Dignity Act — A Critique**

The initiative has been opposed by organizations such as the American Bar

Association, the California Association of Hospitals and Health Systems and the California Association of Catholic Hospitals. Concerns about the initiative center around its ambiguous language and resulting legal problems that will likely involve the Courts in order to resolve them.<sup>21</sup> The problems in the initiative can be focused around two specific areas.

1. *The initiative lacks adequate safeguards to prevent abuse.*

There is no mention of the patient being in "unbearable suffering," an interesting oversight since one of the principal supports for active euthanasia is to relieve suffering that cannot be relieved in any other way than by death. All that is required is that the patient be in a terminal condition, with death expected within six months. Not only is there great difficulty in predicting a person's death within six months,<sup>22</sup> this omission also opens the door for euthanasia much wider than even some of the advocates deem appropriate. All that is medically necessary for a patient to be a candidate for euthanasia is physician certification of a terminal condition with death to occur within six months.

Other problems with the safeguards include the "enduring request" for euthanasia, which is nothing more than a request that is repeated more than one time. There is no waiting period between requests to insure that the request is genuine and not in response to temporary pain or depression, and there is no waiting period between the second request and the time at which euthanasia may be carried out. There is no mandated psychological evaluation of the patient to help insure that the request is a stable one (though the initiative does indicate that it is appropriate to request a psychological evaluation). There is no requirement that alternatives to euthanasia be explained to the patient. There is no specialty requirement for the physicians, either for administering euthanasia or for certifying that the patient has a terminal condition. There is no requirement that the patient's relatives be informed, either of the patient's directive for euthanasia, or that euthanasia has actually been administered to him or her. There is no residency requirement, that is, there is no requirement that the patient be a California resident, thereby opening the door to California's becoming a sanctuary for those seeking to have their lives ended. There is only annual reporting required, making it difficult at best for the State Department of Health Services to adequately oversee and enforce the guidelines that the initiative does contain.

It may be that safeguards are unenforceable in any case. With the high place given to patient autonomy and the privacy that surrounds the setting of one's death, it would not be unusual for the reporting requirement to be ignored. This is precisely what is occurring in the Netherlands, for example, where it is required by law that all cases of euthanasia be reported to the government prosecutors. But that requirement is routinely bypassed and the cause of death is not stated as assisted suicide or euthanasia, but a natural cause is given.<sup>23</sup> Estimates are that less than 5% of the cases of euthanasia in the Netherlands are actually reported, and hardly any are actually prosecuted.<sup>24</sup> With the high place given to physician-patient confidentiality and medical care becoming an increasingly private sphere between the patient and health care team, and with physicians unlikely to report

on their colleagues, it is not hard to imagine how the organization(s) responsible for overseeing the practice could be kept largely in the dark about the frequency with which euthanasia occurs as well as how closely the practice follows the guidelines. Even supporters of euthanasia in the Netherlands admit that the situation there is out of control. For example, Professor H.J.J. Leenen has stated that, there is "almost total lack of control on the administration of euthanasia," and that "the present legal situation makes any adequate control of the practice of euthanasia virtually impossible."<sup>25</sup>

The Dutch, for example, have five specific guidelines that govern the practice of euthanasia, and if they are followed, a physician is virtually guaranteed immunity from prosecution. These parameters include a) the request be voluntary, b) that it be a well-considered request, c) that it emanates from a stable desire of the patient, that is, it is not the result of a temporary emotional condition that adversely affects one's capacity to make decisions, d) that the patient be experiencing "unbearable suffering" in a way that puts the physician in a position in which he or she has no other option, and e) that the decision to administer euthanasia be the result of consultation with other professional colleagues.<sup>26</sup>

The difficulty with these guidelines, beyond the issue of enforcement, is that they are very broad and general, and as a result also somewhat vague. They admit of a variety of interpretations. Take for example, the "unbearable suffering" of the patient. What is unbearable for one patient may not be for another, and the perception of unbearable suffering may be even different for the physician. It is a very subjective criterion and in cases that have been reported, either to authorities or to other researchers, it is clear that this guideline is being interpreted very broadly. For example, in a case cited by Dr. Carlos Gomez, in his interviews with Dutch physicians, a middle aged patient who had been in remission for leukemia had suffered a substantial relapse. She refused any treatment and her request for euthanasia was carried out. It is difficult to see how this patient could have been at the last stages of her illness and thus in pain that could not have been alleviated, yet she was considered a valid candidate for euthanasia. The prosecutor was notified, but dismissed the case.<sup>27</sup> This case shows how the guidelines are being variously interpreted, and how difficult it is to achieve uniformity in understanding what the guidelines mean.

## *2. Voluntary nature of the request is not defined and impossible to enforce.*

In the initiative, there is only one paragraph that deals with this critical part of the practice.<sup>28</sup> All advocates of euthanasia insist that any request for euthanasia be fully voluntary, yet what constitutes coercion is not defined, and even if it were, it is difficult to see how it could be detected and enforced. It does not take much imagination to see how family members could subtly pressure a patient to sign a directive that he or she does not desire. The right to euthanasia could easily become a "duty to die."<sup>29</sup>

In what is becoming an all too common scenario, imagine a patient in a terminal condition, with six months to live. Yet the treatments required to maintain his "health" are rapidly depleting the family's estate. The patient is a financial burden to the family, as the children see their father's estate being



swallowed up by these medical expenses. It would not be difficult to see the motive of the family to encourage their father to sign a euthanasia directive and to "get it over with" before his estate is totally depleted. Add to this the emotional strain on the family as they watch their father's health decline and know that medicine is powerless to reverse his condition. To deal with these emotional and financial aspects of his dying process, he is subtly coerced into signing a directive that he does not really want. The family has a variety of ways in which they could put pressure on him to consent to euthanasia. He finally succumbs to their "encouragement" and requests euthanasia not because he is tired of living, but because others are tired of his living.

Consider too the patients who do not have health insurance, and have no financial way to continue their treatment. With the public health system in this country under increasing fiscal strain, a condition that is not likely to improve short of a dramatic overhaul of the health care system, it is not difficult to see how the lack of options for the poor leaves them vulnerable to signing a euthanasia directive that, if they had the means to afford care, they would not otherwise sign. As the American Bar Association Commission on Legal Problems of the Elderly stated in their opposition to this initiative, "What may be voluntary in Beverly Hills may not be voluntary in Watts."<sup>30</sup> The Dutch system of generous universal access to health care makes it possible for patients to agree to voluntary euthanasia without some of the same kind of financial considerations that are usually so important in this country. It is not hard to see the potential for coerced consent to euthanasia in both private and public hospital settings.

Even the way the physician presents the alternative of euthanasia can undermine a fully voluntary decision. The subtle overtones of the physician can communicate acceptance or encouragement of euthanasia, or even the obligation of the patient to sign a euthanasia directive, and thereby render the decision to have euthanasia administered less than fully voluntary. Such subtle persuasion can also occur in public health care facilities, which as a rule, face increasing pressure to refuse providing expensive end of life care for dying patients. These efforts at "coercion" would normally take place within the confines of physician-patient confidentiality, making such coercion difficult to detect and enforce.

The Dutch practice of euthanasia raises a further concern about the voluntary nature of the patient's request for aid in dying. Many opponents of euthanasia fear a descent down a "slippery slope" that will end up with nonvoluntary euthanasia. Already there is good evidence that euthanasia without consent occurs with alarming regularity in the Netherlands. There is both anecdotal evidence, and more recently, survey data that confirms this.

The term "crypthanasia" has been coined to describe the administration of euthanasia on patients without their consent or knowledge. For example, in a well-publicized case in the Netherlands, a physician was accused of killing twenty elderly residents of the De Terp nursing home in 1984, without their consent or knowledge. He admitted to five of the killings, was convicted of three and had the conviction set aside by a higher Court on a technicality.<sup>31</sup> Witnesses testified that some of the patients who were killed were not actually ill, but senile and difficult to manage, and that the physician threatened other patients with euthanasia

should they prove difficult.

A similar case involved nurses at the Free University of Amsterdam Hospital Department of Neurosurgery. Four nurses admitted killing several unconscious patients, and they were acquitted on the grounds that they had acted humanely in terminating the lives of these patients. The children of the patients publicly thanked the nurses for what they had done, drawing wide media attention.<sup>32</sup> In light of this, it would appear that in some cases, crypthanasia is not considered an abuse of euthanasia, but is accepted as a legitimate extension of voluntary euthanasia.

For some time, the situation in the Netherlands has been difficult to assess because of the scarcity of the data on the practice. But in the last few years, more concerted efforts have been made to discover what exactly is taking place in that country's euthanasia practice. The most well known of these surveys was conducted by the Remmelink Commission, chaired by the Dutch Attorney General, J. Remmelink.<sup>33</sup> In its survey of physicians throughout the Netherlands, the Commission found that in 1990 euthanasia was administered in approximately 2,300 cases, with another 400 cases of physician assisted suicide. Furthermore, physicians acted to hasten the death of patients by withholding or withdrawing treatment in 8,750 cases and by administering opioids in another 8,100 cases. The Commission compared these figures with the 454 cases of euthanasia that were actually reported to the prosecutors and concluded that the overwhelming majority of euthanasia cases were not reported. In addition, in the cases not reported the cause of death listed on the patients' death certificates was fraudulently certified as a natural death.

The Commission further reported that in 1,000 of the cases of active euthanasia and physician assisted suicide, the physician intentionally hastened death *without a specific request from the patient*.<sup>34</sup> In addition, in the 8,750 cases of hastening death by withdrawing or withholding treatment, the great majority of these had been done *without the explicit consent of the patient*. Finally, in the 8,100 cases in which the physician had hastened death by administering opioids, in close to 5,000 of those cases, *the patient had not expressed a desire* for death to be so hastened. Thus out of the almost 20,000 cases in which a physician had acted to hasten death, in close to 75% of them, there had been no request to do so from the patient.

Public opinion polls from the Netherlands show consistent support for nonvoluntary euthanasia, and the Royal Dutch Society of Medicine declared its support for nonvoluntary euthanasia for severely ill newborns, minors, mentally retarded, demented elderly persons and for persons who, in the judgment of the physician, would have opted for euthanasia had he or she been able to voice such a request.<sup>35</sup> One of the cases recorded by Gomez in his interviews concerned an infant with Down Syndrome suffering from an intestinal blockage, for which relatively uncomplicated surgery was refused by the parents. The baby was administered euthanasia, as opposed to allowing the child to slowly starve to death.<sup>36</sup> It would appear from this data that the attempt to contain euthanasia to those cases in which the request is truly voluntary is very difficult, and already there is strong evidence that a good deal of the euthanasia in the Netherlands is



practiced without the explicit consent of the patient. There does not seem to be a way to protect the practice from the abuses that occur as voluntary euthanasia gives way to nonvoluntary euthanasia. Thus it would seem that opponents of euthanasia who fear a descent down a slippery slope have ample evidence to justify their fears. Again, with access to quality health care in the United States being substantially less than is the case in the Netherlands, it is not difficult to imagine the much greater potential for abuse that exists here.

### Conclusion

Even if one accepted the moral legitimacy of active euthanasia, which is not the subject of this article,<sup>37</sup> one should not support the current California initiative. There is great difficulty in insuring that safeguards will be followed and enforced. Furthermore, the model of euthanasia that is practiced in the Netherlands is hardly an encouraging one. It should rather serve as a caution, and a warning about the likely movement from voluntary to nonvoluntary euthanasia. As Daniel Callahan, Director of the Hastings Center, one of the preeminent think tanks in medical ethics, has recently stated, "I am convinced that in the Netherlands there is a substantial number of cases of nonvoluntary euthanasia . . . I see no way, even in principle, to write or enforce a meaningful law that can guarantee effective procedural safeguards."<sup>38</sup> Not only does the California initiative fail to provide adequate protection against abuses, but it is debatable whether this can be done at all.

### References

1. California Civil Code, Title 10.5.
2. The 1990 initiative was called the "California Humane and Dignified Death Act."
3. For further detail on this interesting story in the state of Washington, see Rob Carson, "Washington's I-119," *Hastings Center Report* 22 (March-April 1992): 7-9.
4. The term "loosely legalized" is used to describe the situation in the Netherlands because administering euthanasia is technically illegal there, yet physicians enjoy almost total exemption from prosecution if the way in which they administer euthanasia is in accordance with a set of government guidelines.
5. The California Death with Dignity Act, Section 2525.8. Interestingly, most of this section applies to individuals who would administer aid in dying. It also exempts *private* hospitals such as Catholic and other religious denominational hospitals that might have religious ground for objecting to euthanasia. However, the initiative says nothing about *public* hospitals. Though individuals who work within public settings may be exempt from practicing euthanasia, it is unclear whether entire public hospitals are being offered the same kind of exemption as are private health care institutions.
6. Section 2525.10.
7. Section 2525.2 (k).
8. Section 2525.2 (h).
9. Section 2525.2 (j).
10. Section 2525.2 (i).
11. Section 2525.3.
12. *Ibid.*, pp. 9-11.
13. Section 2525.5.
14. Section 2525.4.
15. Section 2525.17.

16. Section 2525.17 (e).
17. Section 2525.17 (d).
18. Section 2525.17 (c).
19. Section 2525.18.
20. Section 2525.21.
21. For example, only a mentally competent patient can be a candidate for euthanasia. But how is competence defined and, more importantly, who determines it? As is clear from numerous courtroom proceedings, experts disagree commonly when testifying on a person's competence. A further ambiguity is the term "attending physician" who is to certify that patient's terminal condition. In many end of life settings, other specialists are called in, in addition to a family physician and internist. Which one is the attending physician?
22. The current California law, the California Natural Death Act, passed in 1974, states that for treatment to be justifiably withdrawn or withheld, the patient must be in a terminal condition and predicted to die within *two weeks*, with or without continued medical treatment. Predicting death with certainty within two weeks is not that simple a matter, but predicting it with a degree of certainty within six months is very difficult. Note that the current initiative does not specify what probability of the occurrence of death within six months is sufficient to make one a candidate for euthanasia.
23. For further detail on this, see John Keown, "On Regulating Death," *Hastings Center Report* 22 (March-April 1992): 41. In light of this failure to report cases of euthanasia, it is not surprising that supporters of the initiative insist that abuses of the practice are hard to document. It is also a simple matter to understand why such abuses are not documented.
24. Carlos Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands*, (New York: The Free Press, 1991): 117-125. The most conservative estimate of the number of euthanasia cases in the Netherlands annually is around 3,500. There is general consensus that the actual number of cases is somewhere between 8,000 and 10,000 per year, and many opponents of the practice estimate that number is twice that. The Dutch Justice Ministry estimates that, based on the reports it receives, the number is around 300. It is clear that the number of cases reported to the prosecutors is only a small fraction of the number of total cases.
25. H.J.J. Leenen, "Legal Aspects of Euthanasia, Assistance to Suicide and Terminating the Medical Treatment of Incompetent Patients," paper presented at a conference on euthanasia, Instituut voor Gezondheidsethiek, Maastricht, 2-4 December 1990, cited in Keown, "On Regulating Death," 43.
26. Gomez, *Regulating Death*, 40-41, 97-98.
27. This is taken from Gomez, *Regulating Death*, 79-80.
28. Section 2525.18.
29. This "duty to die" has been articulated most recently by then Governor of Colorado Richard Lamm, who insisted that the elderly have a "duty to die and get out of the way."
30. American Bar Association Commission on Legal Problems of the Elderly, "Opposition to Resolution No. 8 on Voluntary Aid in Dying," unpublished paper, 17 January 1992.
31. Richard Fenigsen, "A Case Against Dutch Euthanasia," *Hastings Center Report Special Supplement*, January/February 1989: 6; Gomez, *Regulating Death*, 120.
32. *Ibid.*, 6-7.
33. The following statistics are taken from Keown, "On Regulating Death," 41-42.
34. Though, in fairness, it must be noted that in approximately half of these cases, there had been some discussion of euthanasia with the patient in which he or she had indicated some sort of desire for euthanasia.
35. Richard Fenigsen, "Euthanasia in the Netherlands," *Issues in Law and Medicine* 6 (Winter 1990): 238.
36. This case parallels the first well-publicized case of infanticide in the United States, the 1974 case at Johns Hopkins Medical Center. I would argue that the parents' decision to refuse to authorize the surgery cannot be morally justified, since the real basis for such a refusal was the child's handicap. Both allowing the child to die and active euthanasia should be considered

immoral in this case. The surgery should have been approved, and many children with Down Syndrome grow up to enjoy reasonably productive adult lives. For the details on the case cited by Gomez in his research, see Gomez, *Regulating Death*, 83-84 (Case 20).

37. For further discussion of this part of the euthanasia debate, see J. P. Moreland, (give bib. data for the two pieces on CRI Journal in 1992).

38. Daniel Callahan, "When Self Determination Runs Amok," *Hastings Center Report* 22 (March-April 1992): 54.

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